

## Appendix D: Participant-Centered Planning and Service Delivery

### Appendix D-1: Service Plan Development

<b>State Participant-Centered Service Plan Title:</b>	Person-Centered Plan
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- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	<b>Registered nurse, licensed to practice in the State</b>
<input type="checkbox"/>	<b>Licensed practical or vocational nurse, acting within the scope of practice under State law</b>
<input type="checkbox"/>	<b>Licensed physician (M.D. or D.O)</b>
<input type="checkbox"/>	<b>Case Manager</b> (qualifications specified in Appendix C-1/C-3)
<input checked="" type="checkbox"/>	<b>Case Manager</b> (qualifications not specified in Appendix C-1/C-3). <i>Specify qualifications:</i> <div style="padding: 10px; border: 1px solid black; margin-top: 5px;"> <p>The DDA licenses and contracts with case management services providers, known as Coordinators of Community Services (CCS), through the Medicaid State Plan Targeted Case Management (TCM) authority.</p> <p><b><u>Minimum Qualifications</u></b></p> <p>Each CCS assigned to a participant must meet the following minimum qualifications specified in Medicaid's TCM regulations for people with developmental disabilities and DDA's resource coordination regulations set forth in the Code of Maryland Regulations (COMAR) 10.09.48.05 and 10.22.09.06, respectively, as amended.</p> <p>As provided in Medicaid's TCM regulations, CCS education and experience requirements may be waived if an individual has been employed by a DDA-licensed Coordination of Community Service agency as a coordinator for at least 1 year as of January 1, 2014.</p> <p><b><u>Ineligibility for Employment</u></b></p> <p>As provided in Medicaid's TCM regulations, an individual is ineligible for employment by a Coordination of Community Services provider, agency, or entity in Maryland if the individual:</p> <ol style="list-style-type: none"> <li>1. Is simultaneously employed by any MDH-licensed provider agency;</li> <li>2. Is on the Maryland Medicaid exclusion list;</li> <li>3. Is on the federal List of Excluded Individuals/Entities (LEIE);</li> <li>4. Is on the federal list of excluded parties as maintained by the System of Award Management (SAM.GOV);</li> <li>5. Has been convicted of a crime of violence in violation of Criminal Law Article, §14-101, Annotated Code of Maryland;</li> <li>6. Violates or has violated Health-General Article, §7-1102, Annotated Code of Maryland; or</li> <li>7. Has been found guilty or been given Probation Before Judgment for a crime which would indicate behavior potentially harmful to individuals receiving services, as documented</li> </ol> </div>

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	<p>either through a criminal history records check or a criminal background check, pursuant to Health-General Article, §19-1902, et seq., Annotated Code of Maryland; and COMAR 12.15.</p> <p><b><u>Necessary Skills for a CCS</u></b> Each CCS must possess the skills necessary to:</p> <ol style="list-style-type: none"> <li>1. Coordinate planning meetings;</li> <li>2. Create person-centered plans;</li> <li>3. Negotiate and resolve conflicts;</li> <li>4. Assist individuals in gaining access to services and supports; and</li> <li>5. Coordinate services and monitor the provision of services to participants.</li> </ol> <p><b><u>Required Staff Training</u></b></p> <p>All DDA-licensed Coordination of Community Service providers shall ensure and document that each CCS staff member receives any training required by DDA including person-directed and person-centered supports focusing on outcomes.</p> <p>Each CCS must complete training on using the framework for charting the Life Course. The framework helps participants of all abilities and at any age or stage of life, and their families, develop a vision for a good life, think about what they need to know and do, identify how to find or develop supports, and discover what it takes to live the lives they want to live. The Life Course framework helps participants and their families plan ahead and to start thinking about life experiences now that will help move them toward an inclusive, productive life in the future.</p>
<input type="checkbox"/>	<p><b>Social Worker</b> <i>Specify qualifications:</i></p>
<input type="checkbox"/>	<p><b>Other</b> <i>Specify the individuals and their qualifications:</i></p>

**b. Service Plan Development Safeguards.***Select one:*

<input checked="" type="radio"/>	<p><b>Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.</b></p>
<input type="radio"/>	<p><b>Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.</b></p> <p>The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i></p>

**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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- (a) The CCS provides the participant and his or her family members and legal representative with written and oral information about DDA services and the process of developing a person-centered plan. The CCS assists the participant and his or her team by facilitating the team meeting and creating a Person-Centered Plan.
- (b) The CCS provides each participant and his or her legal representative and family members with information about the participant's rights to determine his or her person-centered planning team. The participant, or his or her legal representative acting on the participant's behalf, may invite family members, friends, DDA advocacy specialists, coworkers, professionals, and anyone else he or she may desire to be part of team meetings or his or her circle of support. The participant is encouraged to involve important people in his or her life in the planning process. However, the participant, or his or legal representative, also retain the authority to exclude any individual from development of his or her person-centered plan with the CCS.

- d. Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

**(a) Development of Person-Centered Plan**

*Who Develops*

The CCS develops the Person-Centered Plan with the participant, his or her legal representative, and the participant's team. The participant is provided the option to direct and manage the planning process, which the CCS facilitates.

Participants can use a variety of person-centered planning methodologies such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long-Term Services and Supports – Needs Template and Before and After Integrated Supports, Essential Lifestyle Planning, Personal Futures Planning, MAPS, PATH, or an equivalent person-centered planning strategy.

*Who Participates*

As further specified in subsection d. above, the participant, his or her legal representative, and family members are the central members of the team responsible for planning and developing a person-centered plan. The participant, or his or her legal representative on the participant's behalf, may invite others important to the participant to be part of the planning process. However, the participant, or his or legal representative, also retain the authority to exclude any individual from development of his or her person-centered plan with the CCS.

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*Timing of Plan*

The plan is developed as part of the waiver application process and updated at least annually, or when there are changes to circumstances or services.

The CCS contacts the participant, and his or her legal representative, to obtain the participant's preferences for the best time and location of the planning meeting. Meetings may be held at the participant's home, job, a community site, day program, or wherever he or she feels most comfortable reviewing and discussing his or her plan.

**(b) Types of Assessments Conducted to Support Development of Person-Centered Plan**

In addition to obtaining a variety of information and assessments about the participant's needs, preferences, life course goals, and health from other sources as specified below, the CCS uses the Health Risk Screening Tool (HRST) and Support Intensity Scale (SIS)®. The HRST assesses the participant's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant. The SIS measures the participant's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports an individual requires.

In addition to these assessments, the CCS gathers information regarding the participant's needs, goals, and preferences from the participant, his or her family, friends, and any other individuals invited to participate in the planning process. The CCS also reviews other formal health, developmental, communication, and behavioral assessments conducted by physicians, mental health professionals, behavioral specialists, special educators, and other health professionals (e.g., Speech Pathologist, Occupational Therapist, Physical Therapist), as appropriate.

**(c) Provision of Information Regarding Available Waiver Services to the Participant**

During initial meetings, quarterly monitoring activities, and the annual plan development meeting, the CCS shares information with the participant and his or her legal representative and family about available waiver services. The CCS also provides information on how to access, via the internet, a comprehensive list of DDA services (including all waiver-covered services) and licensed providers. The CCS assists the participant in integrating the delivery of supports needed. If the participant does not have internet access, the CCS provides the participant with a hard-copy resource manual.

**(d) How Development Process Ensures Plan Addresses the Participant's Goals, Needs, and Preferences**

The DDA requires each CCS to use an individual-directed, person-centered planning approach. This approach identifies the participant's strengths, needs, preferences, goals, access to paid and non-paid supports, health status, risk factors, and other information for a person-centered plan. As part of this person-centered planning approach, the CCS gathers information from the participant, his or her circle of support (family and friends), assessments, observations, and interviews.

Based on a person-centered planning approach, a Person-Centered Plan (PCP) is developed that identifies supports and services to meet the participant's needs, goals, and preferences in order for

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the participant to live in his or her home or community and whether those supports and services will be provided by natural or informal supports, other local, State, and federal programs, or this waiver program. Skills to be developed or maintained under waiver services are determined based on the participant's individualized goals and outcomes as documented in his or her person-centered plan. The PCP will also address any need for training for the participant, his or her legal representative or family, and provider or direct care staff in implementing the Person-Centered Plan.

(e) **How Waiver and Other Services are Coordinated**

The CCS assists the participant in coordinating generic resources, natural supports, services available through other programs, Medicaid State Plan services, and waiver services. The CCS provides case management services, including assisting the participant to connect with this array of services and supports and ensure their coordination.

The Person-Centered Plan (PCP) is the focal point for coordinating services available under various programs, including this waiver, which meets the participant's needs, goals, and preferences as identified in the PCP. The PCP serves as a working plan that details the participant's individualized plan to address his or her specific needs while working towards achieving and maintaining a good quality of life, in accordance with the participant's goals and preferences. The PCP addresses the participant's health, safety, security, community integration, social life, spirituality, citizenship, and advocacy.

(f) **How Development Process Provides for the Assignment of Responsibilities to Implement and Monitor the Plan**

In general, the PCP outlines roles and responsibilities for services and supports.

The CCS is responsible for monitoring implementation of the PCP on an ongoing basis through telephone, e-mail, and face-to-face contacts. The CCS ensures that the services and supports meet the participant's health and safety needs. In addition, when a change in health status occurs, the CCS determines the need for service changes to take place. The CCS also ensures that services are delivered in the manner described in the PCP, and that the participant's goals, needs, and preferences, as identified in the PCP, are being addressed and met.

(g) **How or When the Plan is Updated**

At least annually, or when there is a change in a participant's needs, health status, or circumstances, the participant, his or her legal representative, his or her family, and his or her self-selected team must come together to review and revise the PCP. These required updates to a participant's PCP ensures that it reflects the current needs, preferences, and goals of the participant.

The PCP is updated in accordance with the person-centered planning process identified in this subsection d.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service

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plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

### **Risk Assessment**

During development of the Person-Centered Plan (PCP), the participant's planning team, facilitated by the CCS, assesses the participant's health and safety needs, particularly with respect to the following areas: community safety, health and medical needs, sexuality and relationships, abuse, neglect, elopement, financial exploitation, behaviors, home environment, fire safety, personal care/daily living, mental health, police involvement, informed consent, and others as appropriate to the age and circumstance to the participant. In addition to objective assessments, the family is a key source of information on risk assessment and mitigation when supporting participants under the age of 21.

To promote optimum health, to mitigate or eliminate identified risks, and to avert unnecessary health complications or deaths, the CCS must complete the electronic Health Risk Screening Tool (HRST) for all participants annually as part of the PCP planning process. The HRST is a web-based screening instrument designed to detect health destabilization early and prevent preventable deaths. It is a reliable, field-tested screening tool that consists of 22 rating items, divided into 5 health categories. The outcome of scoring all 22 rating items is an objective Health Care Level that represents the overall degree of health risk and destabilization of the participant. Since each of the 22 rating items receives its own score, the level of health risk can be determined on each of the items as well. Once a participant is fully screened, the HRST produces Service and Training Considerations that can be used by staff and families. Service and Training Considerations describe what further evaluations, specialists, assessments, or clinical interventions may be needed to support the participant based on the identified health risks.

Through the use of the supporting families' tools such as the Integrated Support Star, Life Trajectory, Exploring Life Possibilities, Integrated Long- Term Services and Supports – Needs Template and Before and After Integrated Supports, individuals and families will also assess other areas of risk for the individual in addition to medical concerns.

### **Risk Mitigation Strategies**

After these risk assessments are completed and reviewed, potential risk mitigation strategies are discussed as part of the team meeting, are based on the unique needs of the participant, and his or her family, and must ensure health and safety while affording a participant the dignity of risk. The CCS assists the participant and his or her team in the development of these risk mitigation strategies, which are incorporated into the PCP and service record.

Once identified, the CCS will incorporate the individualized risk mitigation strategies into the PCP, in accordance with the participant's and his or her family's needs, goals, and preferences. Risk mitigation strategies may include: (1) participant, family, and staff training; (2) assistive technology; (3) back-up staffing; and (4) emergency management strategies for various risks such as complex medical conditions, identified elopement risk, or previous victim of abuse, neglect, and exploitation.

In addition, all DDA-licensed service providers must have a system for providing emergency back-up services and supports as part of their policies and procedures, which are reviewed by DDA and Office of Health Care Quality (OHCQ).

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- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The CCS provides information to each participant, his or her legal representative, his or her family members, and other identified planning team members regarding available waiver services, service delivery models, and potential providers. The CCS assists the participant with coordinating and integrating the delivery of supports based on the participant's needs, goals, and preferences.

If the participant is enrolled in the Traditional Services delivery model, the CCS informs the participant of available DDA-licensed providers. The participant, and his or her legal representative, may explore, interview, and exercise choice regarding these potential providers. The CCS assists the participant in scheduling visits with providers and provides a list of providers (including DDA's website).

The CCS and DDA encourages participants to learn about multiple providers, including meeting and interviewing staff regarding services, prior to selecting their provider agency. Potential providers can discuss how they can support the participant and his or her family in a way that meets the participant's needs, goals, and preferences.

For services and programs at a specific location, participants and their families can request a tour, ask questions, and observe classes and programs in order to make an informed choice.

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The OHS ensures compliant performance of this waiver by delegating specific responsibilities to the Operating Agency (DDA) through an Interagency Agreement (IA).

All Person-Centered Plans (PCP) of participants entering the waiver are submitted to the DDA for review prior to service initiation. DDA reviews the PCPs to assure compliance with all waiver eligibility and fiscal and programmatic regulations. Changes to services (amount, duration, scope) in a PCP (through the annual process or due to a change in an individual's needs) must be submitted to DDA for review and approval as per the Modified Service Funding Plan Request policy. PCPs are also reviewed during DDA site visits and OHCQ surveys to ensure they are current and comply with all waiver eligibility, fiscal and programmatic regulations.

In addition, the OHS monitors service planning activity through the quality performance measures. The OHS also retains the right to review and modify service plans at any time.

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary

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○	<b>Other schedule</b> <i>Specify the other schedule:</i>

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

<input type="checkbox"/>	<b>Medicaid agency</b>
<input checked="" type="checkbox"/>	<b>Operating agency</b>
<input checked="" type="checkbox"/>	<b>Case manager</b>
<input type="checkbox"/>	<b>Other</b> <i>Specify:</i>

#### Appendix D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) **Monitoring Implementation of Service Plan and Participant Health & Welfare**

Each CCS is responsible for monitoring the implementation of the PCP and participant's health and welfare. These monitoring activities are required to determine: (1) whether the participant is receiving services as specified in his or her PCP; (2) whether staff ratios are provided as specified in the PCP and Service Funding Plan; (3) whether there is an emergency plan; and (4) whether there were any incidents during the reporting period. Their findings and appropriate actions taken to remediate concerns are documented.

(b) **Methods for Monitoring and Follow-Up Activities**

The CCS conduct these monitoring and follow-up activities through telephone conferences, emails, and face-to-face meetings with the participant, his or her legal representative, his or her family, and service providers. Monitoring and follow-up activities include:

1. Assessment of:
  - a. Services being rendered as specified in the PCP;
  - b. The participant's current circumstances;
  - c. The participant's progress toward goals and intended outcomes;
  - d. The participant's referral status; and
  - e. The participant's needs and supports to maintain eligibility for Medicaid, waivers, DDA services, and any other relevant benefits or services;
2. Identification of any new medical, health, or other needs;
3. Requests for service change and modifications to meet the participant's needs, preferences, and goals;
4. Identification of new support or resource options;
5. Review and, if necessary, revision of the plan for emergencies;

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6. Monitoring of any and all reportable incidents as defined in DDA's reportable incident policy as further specified under Appendix G; and
7. Application or re-application for necessary programs or services to prevent or remedy a gap in eligibility.

(c) **Frequency of Monitoring**

The CCS is required perform face-to-face monitoring and follow-up activities, at a minimum, quarterly basis or more frequently as needed. This monitoring must take place in the different service delivery settings.

**b. Monitoring Safeguards. *Select one:***

<input checked="" type="radio"/>	<b>Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.</b>
<input type="radio"/>	<b>Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.</b> The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>

**Quality Improvement: Service Plan**

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance**

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

**i. Sub-assurances:**

*a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

**i. Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

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<b>Performance Measure:</b>	SP – PM1 - Number and percent of waiver participants who have their individually chosen assessed needs addressed in the service plan through waiver funded services or other funding sources or natural supports.		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): DDA			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample; Confidence Interval = 95
	<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

**b. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

<b>Performance Measure:</b>	SP – PM2- Number and percent of service plans reviewed and updated before the waiver participant's annual review date.		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): DDA			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
	<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other	

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		Specify:	
			<input type="checkbox"/> Other Specify:

c. **Sub-assurance:** Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

<b>Performance Measure:</b>	SP – PM3 - Number and percent of waiver participants who are receiving service in the type, scope, amount, frequency, and duration specified in the Person-Centered Plan (PCP).		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): DDA			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
	X Operating Agency	<input type="checkbox"/> Monthly	X Less than 100% Review
	<input type="checkbox"/> Sub-State Entity	X Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval = 95
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

d. **Sub-assurance:** Participants are afforded choice between/among waiver services and providers.

<b>Performance Measure:</b>	SP – PM4 -Number and percent of waiver participants whose records documented an opportunity was provided for choice of waiver services and providers		
<b>Data Source</b> (Select one) (Several options are listed in the on-line application): DDA			
If 'Other' is selected, specify:			
	<b>Responsible Party for data collection/generation</b> (check each that applies)	<b>Frequency of data collection/generation:</b> (check each that applies)	<b>Sampling Approach</b> (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	X 100% Review
	X Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

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	<input type="checkbox"/> Sub-State Entity	X Quarterly	<input type="checkbox"/> Representative Sample; Confidence Interval =
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Stratified: Describe Group:
		<input type="checkbox"/> Other Specify:	
			<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

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**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DDA's Quality Enhancement staff provides oversight of planning activities and ensure compliance with this Appendix D related to waiver participants.

DDA's Coordination of Community Services staff provides technical assistance and support on an ongoing basis to CCS providers and provide specific remediation recommendations on identified issues. Based on the identified issues, a variety of remediation strategies may be used including conference call, letter, in person meeting, and training. Remediation efforts will be documented in the provider's file with the DDA.

**ii. Remediation Data Aggregation**

<b>Remediation-related Data Aggregation and Analysis (including trend identification)</b>	<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	X Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Sub-State Entity	X Quarterly
	<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
		<input type="checkbox"/> Continuously and Ongoing
		<input type="checkbox"/> Other Specify:

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**c. Timelines**

*When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.*

<input checked="" type="radio"/>	No
<input type="radio"/>	Yes

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